Center for the Study of Traumatic Stress
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Evidence-Based Management for Acute Stress Disorder (ASD)

Acute Stress Disorder (ASD) is characterized by dissociative symptoms (e.g. detachment, derealization, or amnesia) during or after exposure to a traumatic event followed promptly by symptoms of re-experiencing, avoidance/numbing, and hyperarousal from two days to a maximum of four weeks after the traumatic exposure. While not the only disorder seen acutely after exposure to traumatic events, ASD is quite common. The American Psychiatric Association and the U.S. Department of Veterans Affairs Office of Quality and Performance have published Practice Guidelines for the treatment of ASD. For details see:

> http://www.psych.org/psych_pract/treatg/pg/PTSD-PG-PartsA-B-C-New.pdf and
> http://www.oqp.med.va.gov/cpg/PTSD/PTSD_cpg/frameset.htm.

Practice Guidelines do not define the standard of care. However their synthesis of research and expert consensus augments clinical experience in treating patients, educating the public, guiding research, and establishing credibility for medical care delivery. Essential recommendations of the above noted guidelines for ASD are outlined below.

Assessment--Psychological effects of trauma may result from physical injury so detailed diagnostic evaluation should be continued only after a physically and psychologically safe environment has been established, the individual's medical condition has been stabilized, and psychological reassurance has been provided. Diagnostic evaluation may be accomplished through individual or group interviews or consultation. Surveillance instruments or screening symptom checklists may aid the process and may also be helpful in identifying at-risk individuals for follow-up evaluation when large populations are exposed to trauma (e.g. natural disaster or terrorist event).

Management—Objectives for patients with ASD include establishment of a therapeutic alliance, providing ongoing assessment of safety and psychiatric status, addressing co-morbid disorders, and increasing the patient's understanding of and coping with the effects of exposure to traumatic events through specific treatment strategies (e.g. psycho-education, psychotherapy and/or pharmacotherapy) for ASD.

Psychotherapy--Early supportive psycho-education and case management facilitate entry into other evidence-based treatments. Cognitive Behavior Therapy (CBT) may be helpful relatively acutely after traumatic exposure although heightened arousal and anxiety states may preclude some patients from absorbing information or acquiring new coping skills in the immediate aftermath of trauma. Psychological debriefing was developed as an intervention to prevent the development of negative emotional consequences of trauma including ASD, but well controlled studies using single-session individual or group debriefings have not demonstrated efficacy. Some studies have indicated that persons experience these session as helpful. However, if conducted for heterogenous groups some individuals will increase their traumatic exposure through participation.

Pharmacologic Treatment—Potential benefits of selective serotonin reuptake inhibitors and other antidepressants are supported by limited study in ASD and considerable evidence of their efficacy in PTSD. Benzodiazapines reduce anxiety and improve sleep but potential for dependence, withdrawal symptoms, and small studies indicating greater incidence of PTSD after early treatment with this medication class suggest only transient use in acutely distressed individuals.

Combination psychotherapy/pharmacotherapy although not well studied, should also be considered if initial medication therapy or psychotherapy is ineffective.